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POST-RETIREMENT MEDICAL BENEFITS

Moderator: HARRY A. DON
Panelists: WILLIAM J. MINER
THOMAS G. NELSON
JEFFREY P. PETERTIL
Recorder: KEITH J. DALLAS

- o Impact of Financial Accounting Standards Board (FASB) exposure draft
- o Current regulatory environment, tax implications
- o Techniques for estimating potential liabilities
- o Design techniques for controlling liability

MR. HARRY A. DON: We have, as our panel, three members of the American Academy of Actuaries subcommittee on health and welfare plans. This subcommittee provides liaison with the Financial Accounting Standards Board in its project on other Post-Employment Benefits, and has also provided input on legislative developments on retiree medical programs. Tom Nelson, chairman of the subcommittee, will speak on FASB. Bill Miner will be speaking about techniques for valuing retiree medical benefits. Jeff Petertil will be discussing design techniques to limit liabilities.

MR. THOMAS G. NELSON: I, along with the other panel members, am involved in the Academy's subcommittee on health and welfare plans. This subcommittee has been pretty much treated as a kid sister to pensions, and has gotten less written publicity. In mid 1979, there was an FASB exposure draft that addressed both pensions and other post employment benefits. For non-pension post-employment benefits, FASB suggested only adopting disclosure requirements. In 1984, those disclosure requirements were actually invoked.

In 1981, a discussion memorandum was developed. It discussed whether or not accounting for other post-employment benefits should be done on a similar basis to pensions, and associated measurement problems. It also analyzed the legal status difference between pensions and other post-employment benefits, and the cost/benefit relationship of doing the accounting.

In 1982 a preliminary view was proposed which included some alternative conclusions. This document considered other post-employment benefits to be deferred compensation, and tentatively concluded that accounting recognition should be made by companies over the active working lifetimes of the employees. It questioned the measurability of these types of benefits.

In 1983, discussion Memorandum #2 was produced, which dealt with measurement and attribution of costs, the appropriate methods for valuing these benefits, and the transition question.

Finally, in 1984, FASB #81 was produced, which laid out disclosure requirements. It is an interim accounting step requiring a description of benefits, employee group covered, accounting policy being used, funding policy being used (if any), the costs for the current period, and any significant items that might impact comparability of costs. That's the history of accounting for other post-retirement benefits. The recent FASB period has been concentrating on pension issues. Now that those issues have been decided, FASB will be able to consider how to account for non-pension post-employment benefits.

Major issues that will have to be determined are first the reliability of any numbers in the report. That's just a basic accounting tenant. But, specifically to this topic, are these costs material? I think a lot of us in our actuarial valuations have found that the costs on retiree life appear to be material. There are other accounting questions: What is the extent of the obligation? There is no ERISA for other post-employment benefits, so vesting and accrual are uncertain with respect to these benefits. There is a promise being made by employers, but the extent of it is uncertain. Emerging court case law seems to be saying that what has been communicated to employees will affect the extent of the obligation.

Another major consideration is the measurement issue. On the pension side, FASB has begun recognizing costs based on the projected unit credit method. I am not sure that will necessarily apply for the other post-employment benefits. A fourth major area is the recognition and display of data, liabilities and costs. That is a major consideration on FASB's part. The transition issue is also a major concern.

Specifically, a non-issue to accountants is whether or not the benefits are funded. The accountants' policies are to set accounting principles, and it doesn't matter whether there is funding by the employer. Another non-issue is how popular the provisions made in the final statements are going to be. FASB is certainly sensitive to comments, no questions about that. However, if a certain action is a theoretically correct thing to do, FASB will adhere to that and weather the storm. It does, of course, pay a lot of attention to cost/benefit analysis.

What has the Academy's subcommittee been doing? In the past, we have submitted a number of statements. If you want to look up those statements, they are in the Academy's blue journals. Don't start before 1981, however, since that's when most of the activity occurred and statements were made. There have been discussions and presentations to the FASB board. Jeff, Bill and I, a while back, made an educational presentation to the entire Board, and I have talked to the staff who are responsible for that project. About a year ago, we provided the staff with reams and reams of actuarial data. The staff members looked at all this stuff and analyzed it. We sort of silenced them for awhile with so many actuarial valuations. But they did study the data and came back with some good questions.

The basic messages that were in our statements and discussions with FASB were: 1). We will give them all the aid and assistance that we can. 2). We felt that certainly life and medical, and perhaps disability coverages, are material.

The promises vary by client or employer, but some promises are permanent enough to warrant recognition. Since the cost is material, we feel some recognition should be given to these costs. The techniques for measuring these costs are available and we borrow heavily from the pension area. We also stress our

desire to see a flexible approach to techniques -- not necessarily pinning down one technique as appropriate for all situations. The subcommittee also wants to see the reasonable actuarial assumptions used, where we are not pinned down by some rigid set of rules. So, those are the basic actuarial tenants we have tried to convey. We have covered a lot of ground with FASB, and feel we have a strong relationship with it.

My view of the future is that we are coming out of the eye of the hurricane now. There is going to be more activity, not only on the accounting side, but also in the funding area with Congress. We are definitely going to see more requirements from the accountants. I think they are going to conclude that many of the costs are material and measurable. The extent of the obligation may be a judgment call by the auditor. The auditor will need to look into all the promises that are made and into case law in order to make a determination of how these things should be booked. In my mind, that is more of a legal and accounting issue than an actuarial issue.

Transition is going to be a tough issue. It is a virtual wave of costs that can be thrown at an employer's statements. I am hopeful that we won't be pinned down to a single actuarial costing method.

I should mention that there is a new FASB board. There are seven members on the board; two of those members retired as of December 31, 1985, and two new members came on. Thus, tentative conclusions and announcements that have previously been made could be slanted by the new membership. It will be interesting to see how that works out. It is a long decision-making process that they have undertaken.

This long decision-making process has enabled us, as actuaries, to learn more about the theory and practice of evaluating these benefits. Therefore we should be in an extraordinary position to be able to provide good input to the FASB.

MR. DON: The federal government will be a major influence on whatever happens to retiree medical benefits. The thing that makes the government's participation most interesting is that there are two major groups within the

government which are focusing on retiree medical, and they have conflicting objectives. The benefit bureaucracy is essentially concerned with benefit security. The financial group has one very simple goal: not to lose tax revenue. The next few years of federal deliberations are going to shape policies for years to come.

Who is the benefit bureaucracy? Basically, the Department of Labor and the House Labor Committee. What are they concerned with? They are concerned with loss of benefits. How do people lose benefits? They lose them in bankruptcy; they also lose them through benefit reductions.

The first kind of benefit reduction is for current retirees, whereby an employer simply tells the retiree that the benefit is being reduced. Bethlehem Steel is an example.

The other benefit reduction is told to active employees but applies when those employees retire. These reductions do not have the notoriety of the first type, since they do not usually end up in the courts. There are some feelings in Washington that while this type should be permitted to employers, maybe it should not be permitted on an unlimited basis. When you talk about benefit security to government people, you are talking about funding.

Who are the financial groups? The Joint Committee on Taxation, the Treasury Department, and the Senate Finance Committee are the basic players. These groups really have one concern: It doesn't matter what you do, as long as it does not lose tax revenue. If you think those two statements imply the possibility that we will have post-tax funding of these benefits, you are right. It is not a fact, but it is a possibility. The latest action that the government has taken on retiree medical is DEFRA. DEFRA is something of a water shed. It was primarily a victory for the Treasury. The Treasury, again, was primarily concerned with a deficit reduction. The main thing that it did was to immediately cut 501(c)(9) trusts as a method for pre-funding retiree medical benefits. You can theoretically still use these trusts, but there are many pitfalls. Most of our clients are not willing to take the risks involved.

DEFRA also mandated a study of the future course of post-retirement benefits. There are currently two studies occurring. I will focus on the Treasury study. As a first step, the Treasury study is determining the status of current law. It is very much in a state of flux, because it is being made by judges under the old common law system. The judges look at a case, decide on it, and it becomes a law. None of these cases have gone to the Supreme Court yet. There are a couple that are probably going to make it either this term or next, and that will help clarify things. On the other hand, the federal bureaucracy tends to want to have a statute on the books. This Treasury study is pointing toward legislative approaches.

The study is also an attempt to lay out alternatives. The Treasury will discuss defined benefit type programs, such as we have now. It also is going to come up with some things that look like defined contributions. It is going to come up with things that do not exist now. The primary thinking for these new vehicles goes back to the nature of the benefits promise. Treasury wants to clarify the nature of the promise and, hopefully, determine something that everyone can live with. If it tries something too onerous, people will be dropping coverage. The avowed purpose of this study is to be neutral. Its purpose is not necessarily to influence legislation in one direction or another, but to lay out the alternatives and let the people who have to vote on it make the important decisions.

Where do we go from here? The first major item I see coming up is ERISA II. ERISA II poses some very real dangers for all of us who deal with welfare plans. The primary danger is that the government people who deal with this area are essentially pension people. They do not have a lot of hands-on group experience. They tend to take pension ideas and superimpose them onto group benefits. If you try to use straight pension vesting and benefit accrual rules on something like a defined benefit health plan, the results can become an administrative disaster.

The other major item looming on the legislative front concerns the future of Medicare. It is very tempting for the government to make employer plans primary and shift the impending Medicare disaster to the private sector. We will see what happens.

MR. WILLIAM J. MINER: I would like to give you a few things to think about when you look at a retiree medical valuation, and compare it to the pension valuation that many of you do routinely. One of the first things to look at when doing a retiree medical valuation is your interest assumption. It is appropriate to use the same investment return assumption as you are using for pension valuations, if you can accumulate assets in a tax-exempt trust that are sufficient to fund your liabilities over the remaining future working lifetime of an employee. It is often difficult to do that, and so you may want to use a lower investment return assumption for your retiree medical valuation than for your pension valuation.

Let's discuss 501(c)(9) trusts, or VEBAs. DEFRA created very drastic changes in the law relating to those trusts. One of the key changes that DEFRA mandated was that future increases in your claim costs cannot be projected when funding retiree medical benefits. That is not a very realistic actuarial assumption, so when an individual employee retires you may not have enough assets in the trust to fully fund his benefit. Further, there will also be inflation after that employee retires, and this also would not have been anticipated in the funding. The other real difficulty with the 501(c)(9) trust, that leads you towards using a lower investment return assumption, is the fact that there is an unrelated business income tax on investment earnings in a 501(c)(9) trust. There does not have to be very much money in a 501(c)(9) trust for it to be subject to that unrelated business income tax. The general rule of thumb is: If you have more assets in your trust than 3 or 4 months current claim payments, you are going to be subject to an unrelated business income tax on the trust's investment earnings. Thus, if you are considering funding a benefit through a 501(c)(9) trust, it may make sense to use a lower investment return assumption.

Looking at it in the context of funding through a qualified pension plan, using the options under Section 401(h) of the Internal Revenue Code, there are some good reasons to use a lower investment return assumption. The primary difficulty I see with 401(h) is that you cannot contribute sufficient assets into the trust on a tax-free basis. There is the incidental benefit rule that is applicable to all qualified plans. It is described in some very old regulations from the 1960s, which spell out the incidental benefit rule for retiree

medical plans. It says that current contributions to the pension trust for retiree medical benefits cannot exceed 25% of total current contribution to the pension plan, including the contribution for retiree medical benefits. My experience has been that you generally need more money than this 25% to fund a retiree medical benefit. The other main difficulty with using a pension trust is for plan sponsors that have both a qualified pension plan and a profit-sharing plan, or an ESOP. For those employers already contributing almost the maximum tax-deductible limit, which would be 25% of compensation, the retiree medical benefit contributions count against the 25% limit. This can pose problems for employers that are very generous with their qualified retirement benefits.

There are other assumptions required for a retiree medical plan valuation that are not currently made for your retiree pension valuations, or that must be made in a lot more detail. The first such assumption is the medical trend rate. What do you think medical care prices are going to do in the future? The second unique assumption is some sort of morbidity assumption. Medical claim costs increase not only because of price inflation, but simply because the participant is getting older. The morbidity assumption should reflect the increase in medical claim costs as a result of that aging process. Unfortunately, in my experience, it is fairly difficult to find any sort of meaningful data on which to base that assumption. A third assumption, which is really very important in retiree medical valuations, is what you are assuming will occur concerning future Medicare reimbursements. Most retiree medical plans are in some way coordinated with Medicare. The key issue is: How is the relationship between the plan costs and Medicare costs going to change in the future? Is the percentage of the plan cost going to remain the same, increase or decrease? When I was first doing valuations, I never really thought much about this assumption. However, if you consider how much of the liability is deferred after age 65, you begin to realize that if Medicare has drastic future cutbacks, the plan will become responsible for picking up a much larger percentage of the overall cost for post-65 medical care. This means you should be making some sort of explicit assumption about future Medicare payments in your valuation report.

A final assumption that is made in your pension valuations, but requires greater attention for a retiree medical valuation, is an assumption regarding dependents. In a typical pension valuation you assume a certain percentage of the active participants are married. That assumption has some effect on the calculation of your 50% Joint Survivor Death Benefit, but is not very significant. In the retiree medical benefit context, the assumption as to dependent coverage can significantly influence the cost of the plan. The reason, of course, is that the benefits that are provided to retirees are generally also provided to their spouses. If you are high or low in your assumption of the percentage of the people that are married, you are going to have to change your costs drastically.

The final difference between pension valuations and retiree medical valuations lies in establishing claim costs (i.e., the annual costs for the current year for the current retiree population). The best analogy to the claim cost in a pension context would be the actual benefit that a current retiree is being paid. The key difference between the two is: Once an individual retires under a pension plan, you know the benefit amount, and it will not change. When you have someone retire under the retiree medical program, you can establish a claim cost for the current year, but that claim cost is going to change next year as the experience changes. This makes retiree medical valuations very difficult, especially when you are going through a period of high inflation, or high fluctuation in claim costs.

Another key difference is: In a pension context, you can ask the plan administrator what the level of benefit is for a particular retiree. You do not have that luxury in the retiree medical context. You often are the one who is determining the benefit level, and you often do not have sufficient data to make that determination. It is common for the plan sponsor to have aggregated actives and retirees medical claim experience, and have no way of splitting out the retiree claim cost by itself. The other common situation where you have trouble establishing per capita claim cost is when there has been a plan change. You have a new plan provision and no experience on which to base claim cost.

These are some of the problem areas you may encounter in doing a retiree medical valuation.

MR. JEFFREY P. PETERTIL: I want to talk about plan design for a retiree medical, as opposed to the techniques for controlling liability.

The typical benefits structure of a retiree medical plan is a continuation of the active plan. This means the active plan coverage is extended to those who retire early, and at age 65 there is a provision which designates how Medicare will be coordinated with the plan. Exactly which direction Medicare goes then becomes a very key aspect of the cost of the retiree medical plan. Medicare deductibles have been increasing at a rate of something like 16% per year since 1981. Compare this to CPI inflation of around 5%, and a medical trend rate in the 10% category.

The Medicare part A deductible is based on a hospital charge per day. Because of various things that have happened in medical economics, it was $400 per day in 1985, and went up to $492 in 1986, a 23% increase. The speculation about the 1987 figure is a $570 deductible for the first day. The same increases, including the 23% increase in the first-day hospital deductible from 1985 to 1986, have also been reflected in the copayments for both hospital care and nursing home care. What this means for a plan standing secondary to Medicare is that there could be a 23% increase in costs from 1985 to 1986. You can now understand the need to take into account in your projections where Medicare is going. One way to look at your plan is to examine what provision you have for integrating with Medicare: coordination, exclusion, or carve-out. If someone tells you their plan coordinates or carves out, examine how the claims administrators are really administering it. The carve-out is the least expensive from an employer's standpoint; most people believe that their plans are integrating by that method. I have known two cases where I have been told that there was a carve-out, but there actually was a coordination. Essentially, coordination is very similar to that under an active plan, where in this case Medicare is the primary coverage, and the plan is the secondary. With coordination, there is a very good possibility that the member, the employee, or the dependent will end up paying no costs at all, because the combination of Medicare and the employer plan will pay for everything. The carve-out plan, on the other hand, says:

"We have cost-sharing and that cost-sharing is going to be maintained." The employee is going to have to pay the same amount, in terms of cost-sharing, as if Medicare did not exist. Essentially, whatever the employee might pay under an active plan is what they would be paying under a retiree plan. It is hard to determine the exact savings there would be from a carve-out versus a coordination design, since it depends on the plan that you are examining. However, it is easy to imagine the situation where carve-out costs would be two-thirds or one-half of those under a full coordination plan.

Another Medicare interaction is the definition of reasonable and customary, because Medicare's idea is very often different from that of an insurer or a TPA. The prospective payment DRG system, used by Medicare, has been good for total costs, but it is encouraging more outpatient use. For most plans, outpatient coverage typically is covered under the employer plan more heavily than it would be under Medicare -- thus, additional employer costs.

A word or two about recent court cases, and the restrictions they seem to have placed on your plan design -- although there are no statutory laws which limit the ways employers can modify plan benefits, there have been a few court cases in the last three years which have set some standards. Most publicized of these was the Bethlehem Steel case, in which the company made reductions in benefits for those already retired, and the retirees brought a class-action law suit against the company. The retirees prevailed in the trial court and the case was settled before it went to appeal. The trial court essentially said that benefits could not be changed for those already retired. Although the settlement did result in some slight cut-backs, precedent was set with this case. Other cases have limited employers' rights to change benefits for retirees, and implied the benefit reduction for the post-employment benefits of those still active would also be restricted. As of yet, none of these cases have reached a high appeals court or the U.S. Supreme Court. It may be that legislation will be enacted before such a court precedent occurs. For now, employers' right to change benefits is severly limited for those already retired.

Those not far from retirement age also may need to be protected. In this situation, there has been more of a threat from the courts, rather than actual

decisions. The biggest lesson to be learned from the court cases is: Be sure that your client is communicating to his members what he truly intends the commitment to be. In the Bethlehem Steel case, there were plan documents which said something quite different from what was actually being communicated to people at exit interviews. The exit interviews are what the courts found to be the guiding rules.

Utilization review is commonly considered to be the most successful of the cost containment strategies, with cost-sharing being a close second. Both concepts are going to be harder to implement in a retiree plan than in an active plan. The utilization review usually depends on having a common site or sites, while many retirees may have moved away from the original work place. This makes a UR program difficult to administer for retirees. As far as cost-sharing, if Medicare pays the costs that the employees normally would have to bear under an active plan, the cost-sharing incentive is not going to work in the same way that it would when there is no secondary coverage. Cost containment through alternative delivery systems (PPOs, HMOs) has the same geographical problems that utilization review would have. You may want to do a geographic survey if you are looking at some of these plan design changes.

Eligibility requirements: More employers are looking at putting in a different plan for those employees who have less than, for instance, thirty years of service. We will be seeing more of these changes in the future, and actuaries will be involved in both the evaluation and the design of such plans. Additionally, I think we are going to have to start looking at the age of retirement. Costs before age 65 are a lot higher for the employer than they are after age 65. Therefore, we get into a problem of inequity. The present value of the liabilities for the age 55 retiree is double that for the person retiring at age 65. It is much more skewed than it would be in a pension plan.

Another idea is the use of a lifetime maximum, with the idea that you will change that maximum, maybe every two or three years. At the same time the maximum is changed, you may raise the deductible, or maximum out-of-pocket limit. A plan today that falls under the Bethlehem Steel rule and has no lifetime maximum is probably in a lot of trouble.

Finally, a point about the larger retiree health care issues. Medicare and retiree medical plans are supposed to cover most of the health care needs of the elderly. They do not. The fact that the conservative Reagan Administration has introduced a catastrophic health plan is a definite sign that the current system is inadequate to cover the needs of the elderly. Medicare pays for less than half of the health care costs of those over 65. When you look at hospital costs, it pays 75%. When you look at physician's costs, it pays 50%. What isn't it paying for? It is not paying for long-term and chronic care. Very few of the retiree medical plans sponsored by employers are paying for that care either. The actuarial profession and the insurance industry need to address this issue. As high as the cost can be for the current retiree employer plans, they are not adequate to cover the full needs of the elderly. We have a real problem. I think that the people in this room -- the insurance industry, the actuarial profession -- are going to have to address some way of financing long-term care for the elderly. A lot of cost containment ideas can also be used in that area, but it is a challenge for the future.

MR. STEVEN G. VERNON: I would like to hear some of your possible solutions if you were faced with a client that said, "I am concerned about rising costs. What kind of things can I do with regard to plan design, communications, and funding?"

MR. PETERTIL: The first thing I would say is, "What is your current plan design, and what are you communicating?" What they are communicating and what they are actually doing may be two different things. As far as plan design, I would be very concerned if there is no lifetime maximum. I would also be concerned if there is a straight coordination of benefits provisions. I would move towards the exclusion or the carve-out as quickly as I could. This change will probably be for the active employees, those about ready to retire. You probably want to get the advice of counsel as to what might be done on the retiree plans. None of the court cases that I know of turn on a carve-out versus a coordination change. If a plan had coordination for retirees, and changed to a carve-out, I would consider that to be a benefit takeaway. But so far those cases have not come up.

MR. DON: Another item is, "How can employee contributions be used to control employer costs?" You want to be sure you have the right to raise contributions in the future. Typically, employees will pay 20 or 25% of the total cost. If you want to limit your liability, you could only guarantee employer support of costs to a certain level. For instance, in 1986, the employer is paying $40 a month per person for over 65 coverage. That employer could only guarantee to pay $40 a month in the future, and pass any future cost increases onto the employee. Now, as a matter of policy, the employer can raise those year by year, but as long as you don't make the commitment up front beyond your current level, you have taken probably 60 or 70% of the cost of the benefit away by eliminating future inflation and placing that responsibility on the employee.

MR. MINER: In conjunction with your suggestion, if you are going to limit that company contribution to $35 or $40 a month, the approximate monthly cost of a Medicare supplement, you should also be looking at not providing any retiree medical coverage until after age 65.

MR. NELSON: Some other ideas: A sunset provision in the coverage whereby the employer would only provide coverage for the next two years. He would then renew it if he desired. Another possibility would be changing to a schedule of benefits.

MR. DON: Two possible arguments against this idea are: 1). You would have trouble with the sunset, because the courts are tending to interpret these as status benefits. You might be better off guaranteeing a current level of costs in the future than in trying to put in a sunset provision that chops the benefit. 2). The sunsetting could also cause a lot of retiree resentment, because they don't know what they have. The schedules will only work if you do not have a major medical coverage on top of the basic coverage. If you have a major medical, all excess costs will fall into a major medical, defeating the purpose of the schedule.

MR. JOHN M. BERTKO: This question is for the whole panel, but to Tom Nelson in particular, as the Chairman of the Academy subcommittee. What do you think would be the qualifications for an actuary to sign off on an official version of a valuation summary?

MR. NELSON: That is a good question, and one we've discussed in our committee meeting, as well as a number of times in the Academy. It could get very complex in defining who would qualify for this kind of actuarial certification. There are pension actuaries who have an awful lot to offer in terms of knowledge about projections of this type. It is not necessarily in the group actuaries' background to do some of these projections. Familiarity is the key. Some of the key assumptions, however are far more into the realm of health actuary. Thus, it is best to have both the experience of the pension and health actuary involved.

The qualified actuary requirements that DEFRA proposed have not been clarified by Treasury. We try to keep in tune with what Treasury's thinking is on this. The last I heard, Treasury is not addressing this currently, since there are many other things on its docket. I would hope that whatever happens, the decision will be made in a fashion that will recognize past experience. I think it is also imperative to have somebody with group and with pension experience involved. That could very well be somebody who does not necessarily have all the credentials of people who are in this room.

The area of designation of certified actuaries is one where we have a danger that the government is going to treat this as a pension problem, not as group insurance. The government may feel that, having invented the enrolled actuary, "if you have seen one actuary you have seen them all." As somebody who has worked both sides of this issue, my own personal opinion is that the group insurance part is a lot more important, and tougher to learn than the pension. The group insurance expertise goes right to the heart of the benefit obligation, and there are treacherous parts of a valuation that you can miss if you do not know group benefits. The pension funding is not easy, but is relatively straightforward.

One more comment. . .When DEFRA was written with a "qualified actuary" definition, we contacted Ira Cohen and his staff immediately. We put on a presentation for them -- a day long seminar to basically help them understand some of the reserving techniques that are involved and the complications of the retiree question. We will try to keep that channel open so when they do get to make a decision, we will be able to assist them in defining a "qualified actuary."

QUESTION: For the purpose of talking with someone who knows nothing about these plans, do you have an approximate figure for the average cost of coverage for a retired versus an active person?

MR. PETERTIL: That depends on the plan provisions and many other factors. From a Chicago area standpoint, I often use the figure for someone age 62, with a spouse age 59, of $30-$50,000 for lifetime benefits.

MR. DON: I do not think too many of us will argue with that. The things that influence costs are: 1). The benefit level. That is, to a large extent, determined by your coordination provision. COB is going to be a lot more expensive than carve-out, particularly if you have an underlying comprehensive major medical plan. 2). The extension of the benefits. If you extend benefits to a spouse, it typically costs just as much as for an employee. That doubles the cost. Another big factor is the retirement age. Roughly speaking, Medicare covers about two-thirds of the covered cost of a plan. Thus, without trying to get too fancy, when you go from "under 65" to "over 65," your costs drop off by about two-thirds. Therefore, those pre-65 years are very expensive. It is not like a pension plan, where you have an actuarial reduction and to a large extent do not care when someone retires. I would guess the $30-$50,000 is assuming Medicare is available. If there were no Medicare, then you are talking $100-$200,000.

MR. DENNIS J. HULET: I remember a statement in the pension study material which said that the pension benefit level should be determined by what the employer feels is an acceptable standard of living for his retirees. It seems to me we have now said, "Pension benefits are going to provide for certain aspects of cost of living, but not for medical care." Why haven't we coupled these thoughts together, and said, "We need to increase retirement benefits so that these benefits can provide adequately for medical care?" In working with a particular client who had all kinds of money, his concern was not so much being able to fund the amount that we said was necessary to provide benefits. His concern was that his liability seemed to be so variable based on what the government might do, what the mortality assumptions were, what inflation might be, and the unlimited nature of the risk. We suggested that, rather than going the defined benefit route, he ought to consider the defined contribution

approach and set up funds for each of the employees from which they could either take premiums out after retirement or pay their medical costs directly. What do others think about that kind of approach?

MR. DON: You probably anticipated something that is being suggested by Treasury. My comment, unfortunately, is that the cost is not flat from the retiree standpoint. We may talk about $60 a month per head in the aggregate, but some of those retirees are generating nothing and some of them are generating catastrophic medical bills. This makes for legitimate needs for insurance. Current benefits are essentially needs benefits. The Treasury study is going to need to reconcile the defined contribution approach with the varying needs of retirees.

MR. PETERTIL: I do not think the case has been made for either the IRA for health care or the 401(k) for health care, which is the defined contribution plan proposed by Treasury. The only case that has been made is a financial case. It is not addressing the health care need of this nation, or our society. I, for one, will be very concerned if that is the direction legislation takes. You have financial control, but with inflation, the aging factor, and the possibility that Medicare may be eliminated it is not the societal solution that we need.

MR. NELSON: I feel, with the Retirement Income Policy Act that is being considered, Washington is also beginning to recognize the need to consider the retiree medical policy. I foresee another "three-legged stool" with some governmental involvement, some employer involvement and perhaps a medical IRA. Together, they will cover the entire societal needs.

MR. GREGG L. SKALINDER: In working with our clients, we have found that there is tremendous concern by employees. I think it is fairly realistic in the long term, with a concentrated communications effort, to educate employees to the point where they will be willing to take cut-backs in other areas in exchange for this coverage. Our attitude surveys show that the concern goes very deep, down to people in their 30s and 40s. Thinking very long term, trading off other benefits for this coverage may be a viable way of controlling employees' costs.

We have had a very difficult time finding any statistics on the costs of these plans, even related to particular ones. We have approached a number of insurers that work with our large clients, and have found that even they do not have the statistics. Is there anything published, that is in the public domain, which can help people in a situation like ours?

MR. PETERTIL: I think that, as far as canned costs, you should be distrustful of anything that you see. As far as inflation and utilization trend factors, a couple of the articles that have appeared in *TSA* in the 80s should be helpful. I think one is a study of Medicare costs, and another study is on the Blue Cross of Upper New York. Both of those had some breakdown costs above age 65. Finally, Medicare data is published on a quinquennial age basis annually.

On the other hand, I think you have to look at the current plan of what employers are paying for retirees, and maybe at what they are paying for actives. Then do some age rating on that data to get costs that you can use as a projection base. Our concern is the need for really good group health analysis, since we have each seen examples of errors in the magnitude of three or four just by incorrectly estimating the current costs. The projection method was fine, but they did not get the base number right.

MR. NELSON: I would concern with what has been said before. There are so many variables involved that I would be distrustful of using somebody else's experience. You never get quite the right level of detail to determine what their experience really represents. There is no shortcut to going into the detail of the plan being studied.

MR. GREGORY TODD SWIM: I would like to emphasize the need to be very careful in evaluating the ability of medical technology to extend life. We have read a lot of things about euthanasia, but clearly the ability of our medical technology to extend future morbidity costs is going to be considerable. You do not want to overlook that when you project things 10 and 15 years into the future.

MR. J. MARTIN DICKLER: I understand there is one insurance company that has offered to buy out the employer's liability for this benefit. It happens

to be the same insurance company that did a preliminary valuation for a client of ours, which the client did not believe. They came to us and we felt that the insurance company had woefully underestimated the lifetime costs.

MR. HULET: We found that many large employers are willing to take on the current under age 65 insurance costs. However, such a large portion of America works for the small employer, and it seems to me we are going to find it very difficult to get small employers to take on that kind of risk. We need a whole bunch of insurance companies that are going to come up with these single premium retiree medical policies, but I wonder if there are any insurance companies out there that are even working toward that kind of a product?

MR. DON: Having worked for one major insurance company that considered risk to be a four-letter word, I am not confident that any of the insurers are going to be willing to take on that risk at a realistic price. I am not sure I blame these insurers. Under group insurance, the insurance element from the carrier standpoint is strictly a one year deal. Carriers are not particularly constituted, except for long-term disability, for getting into something that has that longer term kind of risk.

MR. JOHN K. NINOMIYA: There has been a lot of discussion about the Medicare benefit and how it is changing. I have not heard much about the HMO. I think capitated programs are going to have significant impact. For example, in Long Beach, California there was one HMO that offered a senior plan. It got 16% of market penetration in 10 weeks. How is all that being factored into the larger picture of post-retirement medical benefits?

MR. DON: Most of us would welcome the HMO. Unfortunately, in Cleveland you do not find HMOs offering senior plans. California is much more active. It varies around the country.

MR. NELSON: In Chicago, HMOs just are not really significant for retirees. In the evaluations I have done where there has been an HMO available, I generally ignored them because I do not have many retirees that are covered by the HMO.

To the extent that the HMO can do something with risk bearing and controlling costs, these facilities offer some hope. But when you are looking at it from an employers' standpoint, you are still looking at an HMO rate. You do not know what is going to happen to that rate in the future and that is the major element of risk.

Typically, HMOs are contracted directly with the Health Care Financing Administration on a capitation basis. The pattern in Southern California is that HMOs will offer a low option, with no deductible, that co-pays to the insured simply for what they are receiving from the government. The high option is usually $5 to $10 more a month and covers drugs and refraction, etc. There seem to be big potential claims costs savings for whatever supplementation would go on from the employer.

MR. PETERTIL: In the short-term, that is clearly true. But the question I would have in advising a plan sponsor is that it is not clear to me that the HMO savings that I have today will continue for 30 years. This is the element of risk that I am worried about.

I would take the short-term savings, even though I could not guarantee them in the long-term. These plans may pick up some of the employer-sponsored liability, since presumably they are using tight utilization controls, etc. We should be skeptical about the HMO's effectiveness, but certainly welcome its entry into the marketplace.

MR. CARROLL R. HUTCHINSON: What minimum periods of service are companies requiring before providing post-retirement medical benefits? What variations are being imposed for early, versus normal retirement medical benefits?

MR. DON: Until the last couple of years, the typical answer was zero. The last employer got stuck with the liability. That was before people knew the magnitude of the liability. Now it is usually the same as the pension eligibility. You may get a very minimal pension, however, and the entire medical benefit.

Typically, if an employer has contributions, the employee contribution level will be higher before age 65 than after age 65. And one of the things we are recommending, is that the contribution schedule vary by length of service. Basically, you run it backwards. For instance, you say the employer will provide 3% of the cost per year up to 30 years of service. If an employee has 30 years of service, he is paying 10%. If he has 20 years of service, he is going to pay 40%. That seems to satisfy a sort of ill-defined sense of equity on both sides, and keeps the employer costs down. The rates would be re-adjusted every year, but the percentages would stay the same. If a person retires with 25 years of service, the employer would always cover 75% of the costs.

MR. MINER: Let's say you have a group that is mostly retirees now, their average age is 66, you are spreading one cost for all retirees, and each new retiree will be charged based on their length of service. In twenty years, you will have a mixture of 85 year olds and 65 year olds. The 85 year olds will truly have double the costs of the 65 year olds, but since you still have one rate, the higher cost of the 85 year olds will essentially be subsidized by the shorter service 65 year olds. The one rate, as time goes on, will raise questions of equity between generations.

I had one client who previously provided retiree medical to all who received a pension benefit. The client now requires 20 years of service in order to get the retiree health.

MR. ROGER L. VAUGHN: I would like to ask a question related to the interest rate and the medical care inflation assumption. Given an after-tax investment assumption of, say 6%, what is a range of reasonable medical care inflation assumptions that you would be comfortable with?

MR. PETERTIL: I would say that the projection I would make for medical inflation would be a point, to a point and a half above general CPI.

MR. NELSON: With a recent project I was on, I happened to look at the difference between the CPI and the medical CPI over the last 25 years. It was just under a 2% difference for those two CPI rates. The real key is knowing the

difference between the investment assumption and the medical trend rate. The two are so intertwined that we always speak of them in our valuations in the same breath. The absolute difference is the important part, not the absolute size. When you pin us down to 6%, it makes the answer a little bit easier.

MR. VAUGHN: Have you done any valuations with negative spreads?

MR. NELSON: I tend to look at the possibilities. We normally sensitivity test different assumptions. We will use either side of zero just to examine the possibilities. The results could be startlingly different.

MR. DON: The key point is that anybody who does just one run is letting themselves in for all kinds of trouble. You want to give the client helpful information. I think that includes a range of costs.